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Sexually transmitted diseases

Extract from the Annual Report of the Chief Medical Officer to the Department of Health and Social Security for the year 1971

During this year the venereal disease services have faced an ever increasing pressure of work. There have been increases in medical staff, improvements in clinic premises, and some expansion of the clinic services, particularly in the Greater London area which deals with nearly half the case load for the whole of England. Of the three main venereal diseases, syphilis is not on the increase, but the diagnosis of over 1,000 early infections remains a challenge. Further efforts must be made to eliminate the remaining 'hard core' of this protean and potentially lethal disease. The new case figures for gonorrhoea continue to increase, although it is here that the main control effort is being made. Some encouragement may be derived from the increasing proportion of infected women brought in, mainly by the contact tracing services, and from the fact that the rate of increase was less marked in the later part of the year.

Other sexually transmitted diseases also remain a major problem. For the first time this year separate case figures are available for all these diseases. The so-called non-specific genital infections continue to form the major group and if the majority of these infections are, as most believe, sexually transmitted then it seems likely that, as with gonorrhoea, many symptomless infected females remain undiagnosed. This fact emphasizes the importance of current research into the aetiology of the condition which could ultimately lead to suitable diagnostic tests being generally available.

In the international field the United Kingdom is almost unique in having a fully integrated service staffed by physicians specializing in venereology. Few other countries have reliable statistics even on the incidence of syphilis and gonorrhoea, and none publish statistics on the other sexually transmitted diseases. Efforts by WHO to correlate national figures made available in the past have shown the United Kingdom low in these comparative Tables based on incidence per 100,000 population.

'On the State of the Public Health' (1972). Report of the Department of Health and Social Security for the Year ended December 31, 1971, p. 66. H.M.S.O., London

Syphilis

The definition of early syphilis includes the primary, secondary, and early latent stages. In 1971 there were 1,606 cases (1,270 in males and 336 in females), giving a combined incidence of 3·48 per 100,000 population as compared with 3·42 in 1970 (Table I). The male : female ratio in 1971 was 3·8 : 1 as compared with 4·8 : 1 in 1970. If the latent cases are excluded, then the total of early infectious syphilis for 1971 was 1,132 cases (921 in men and 211 in women), giving a combined incidence of 2·46 per 100,000 population as compared with 2·42 in 1970. The male : female ratio in 1971 was 4·4 : 1 as compared with 5·1 : 1 in 1970.

The figures are marginally above those of the previous year though maintaining a low level of new infections. The small increase was in females and this is attributed to greater and more extensive efforts in contact tracing. Further intensification of effort could begin to reduce the figures. The ratio of males to females given is misleading, and as reported last year the British Co-operative Clinical Group of the Medical Society for the Study of Venereal Diseases made a survey in 1971 which indicated that, if infections acquired homosexually are omitted, the male : female ratio is approximately 2·4 : 1.

Table III (overleaf) gives the number of cases in which early infectious syphilis was believed to have been contracted in the United Kingdom or abroad. The proportions are similar to those in recent years, 17.8 per cent. being contracted abroad as compared with 15 per cent. in 1970 and 17·1 per cent. in 1969. This nonetheless indicates a not inconsiderable inter-country spread of infection to which a number of homosexuals who frequently travel abroad may make an appreciable contribution. A meeting convened in Copenhagen at the end of the year by the European Headquarters of the World Health Organization considered problems of the inter-country spread of venereal disease, and it is to be hoped that their recommendations will lead to improvement in

TABLE I *The venereal diseases—new cases per* 100,000 *population, by age, seen at hospital clinics in England* 1967-71

Year	1967			1968			1969			1970			1971		
Sex	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Early Syphilis															
All ages	5·97	1·43	3·64	6·25	1·57	3·84	5·86	1·28	3·51	5·82	1·11	3·42	5·67	1·42	3·48
Early syphilis (primary and secondary only															
All ages	4·63	0·99	2·76	4·65	0·95	2·75	4·43	0·87	2·60	4·21	0·77	2·42	4·11	0·89	2·46
Under 16	0·03	0·04	0·04	0·05	0·02	0·04	0·03	0·05	0·04	0·03	0·03	0·03	0·05	0·07	0·06
16 and 17	2·45	2·38	2·41	2·35	2·61	2·48	3·00	3·29	3·14	2·21	1·63	1·92	2·64	1·80	2·23
18 and 19	9·05	3·52	6·30	7·63	4·48	6·07	9·37	6·19	7·79	5·98	4·32	5·16	7·97	5·17	6·59
20–24	12·55	4·13	8·35	15·08	3·79	9·46	14·35	3·22	8·82	13·51	3·69	8·62	13·80	3·64	8·75
25 and over	5·47	0·80	3·00	5·24	0·74	2·86	4·87	0·56	2·59	4·74	0·53	2·51	4·53	0·67	2·49
Late syphilis															
All ages	4·25	2·88	3·54	4·24	2·83	3·52	3·75	2·45	3·08	4·00	2·07	3·01	3·79	1·55	2·64
Congenital syphilis															
All ages	0·38	0·49	0·44	0·42	0·61	0·52	0·38	0·61	0·50	0·32	0·45	0·39	0·38	0·49	0·44
Gonorrhoea (post pubertal)															
All ages	135·52	46·42	89·70	142·70	50·94	95·56	158·34	60·84	108·26	164·31	69·69	115·72	169·26	75·90	121·26
Under 16	0·71	3·19	1·92	1·25	4·19	2·69	1·36	6·22	3·73	1·35	7·01	4·11	2·15	7·03	4·53
16 and 17	87·18	161·20	123·55	105·32	193·92	148·72	131·11	248·64	188·64	143·23	316·00	228·13	161·37	348·62	252·47
18 and 19	310·46	281·22	295·93	359·99	315·22	337·82	466·05	412·36	439·31	503·69	508·25	505·95	523·91	558·80	541·06
20–24	549·41	231·64	391·07	572·60	248·22	411·11	625·86	290·25	458·98	643·41	331·95	488·53	683·29	370·68	527·46
25 and over	134·28	25·55	76·79	138·49	27·66	79·95	151·23	31·49	88·00	156·75	33·94	91·91	159·26	36·58	94·30
Chancroid															
All ages	0·25	—	0·12	0·22	0·01	0·11	0·24	0·01	0·12	0·20	0·01	0·10	0·22	0·02	0·12

TABLE II *Other sexually transmitted diseases and other conditions—new cases per* 100,000 *population at all ages and by sex seen at hospital clinics in England* 1967-71

Year	1967			1968			1969			1970			1971		
Sex	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Lymphogranuloma venereum	0·24	0·02	0·13	0·24	0·01	0·12	0·13	0·02	0·07	0·18	—	0·08	0·20	0·01	0·10
Granuloma inguinale	—	—	—	0·04	—	0·02	0·01	—	0·01	0·03	—	0·01	0·02	—	0·01
Non-specific genital infection	142·43	—	—	155·78	—	—	178·20	—	—	204·79	—	—	263·55	56·54	157·13
with arthritis	1·55	—	—	1·32	—	—	1·61	—	—	1·65	—	—	1·88	0·13	0·98
Trichomoniasis	—	—	—	—	—	—	—	—	—	5·73	61·00	34·12	5·80	73·46	40·59
Candidiasis	—	—	—	—	—	—	—	—	—	—	—	—	12·86	90·90	52·98
Scabies	—	—	—	—	—	—	—	—	—	—	—	—	11·29	3·10	7·08
Pubic lice (pediculosis pubis)	—	—	—	—	—	—	—	—	—	—	—	—	13·71	4·15	8·80
Herpes simplex	—	—	—	—	—	—	—	—	—	—	—	—	12·22	3·95	7·96
Warts (condylomata acuminata)	—	—	—	—	—	—	—	—	—	—	—	—	39·81	20·32	29·79
Molluscum contagiosum	—	—	—	—	—	—	—	—	—	—	—	—	1·66	0·60	1·12
Other treponemal diseases	2·11	1·83	1·97	2·31	1·86	2·08	2·20	1·45	1·82	2·28	1·38	1·81	2·42	1·18	1·78
Other conditions															
Requiring treatment	—	—	—	—	—	—	—	—	—	—	—	—	93·44	36·09	63·96
Not requiring treatment	126·67	66·51	95·73	140·05	71·86	105·02	162·67	85·58	123·08	167·37	89·70	127·48	199·66	103·59	150·27

international contact tracing methods in future years.

Information of the age breakdown in cases of early infectious syphilis per 100,000 population obtained from the clinics is shown in Table I. The distribution is relatively unchanged with the highest incidence in the 20 to 24 year age group at 8·75 as compared with 8·62 in 1970.

During 1971 it was possible to take action regarding the contacts of 1,220 cases of syphilis, 938 males and 282 females. As a result of these measures, 676 male contacts were examined and 144 of these were found to have syphilis; 1,250 female contacts were examined and 124 of them were found to have syphilis. Contact tracing action by venereologists was greatly facilitated in many clinics by welfare officers (seconded by medical officers of health) who interviewed patients and searched for contacts, aided in some cases by the health visitors of local authorities.

Cases of late syphilis declined from 1,392 in 1970 to 1,217 in 1971, giving an incidence of 2·64 per 100,000 population. In 1971 there were 99 cases of cardiovascular syphilis, 72 in men and 27 in women, the same total as in 1970. The 1971 figures for neurosyphilis were 129—94 in men and 35 in women; this compared with 164 in 1970—113 in men and 51 in women. There were 989 cases at all other late and latent stages, 683 in men and 306 in women. Figures from the Registrar General's Annual Review in 1971 recorded deaths in eight men and four women with general paralysis of the insane, in thirteen and three women with tabes dorsalis, and in eleven men and eleven women with syphilitic aortic aneurysm.

The number of new cases of treponemal diseases presumed to be non-syphilitic continues to decrease. In 1971 there were 821 cases reported from the clinics, giving an incidence of 1·78 per 100,000 population as compared with 1·81 (Table II) in 1970. This probably reflects a further fall in immigration from regions with endemic yaws.

The figures for congenital syphilis slightly increased. The figure for all congenital infections was 201 as compared with 183 in 1970, an incidence of 0·44 per 100,000 population as compared with 0·39 in 1970 (Table I). The figure for early infections was sixteen.

This incidence is low, but control methods by blood testing of pregnant women clearly must continue. The number of tests for syphilis in five regional centres (Table IV) is little changed from last year, and resulted in the diagnosis of syphilis in 87 pregnant women, as compared with 108 women diagnosed in 1970. Recently there have been suggestions that regulation blood tests for syphilis on infants for adoption could be abandoned, but the mothers of these infants may be in a group with a higher than average risk of infection and the precaution seems of real value unless it can be shown that positives do not occur.

Gonorrhoea

This infection is still uncontrolled, although the increase this year is less than in the previous year. There were 37,929 new cases in males and 18,059 in females. The post-pubertal figures were 37,905 in men and 17,985 in women; this gave an overall incidence of 121·26 per 100,000 population with a figure of 169·26 in men and 75·90 in women compared with 115·72, 164·31, and 69·69 respectively in 1970 (Table I). The male and female case ratio was 2·1 : 1 compared with 2·2 : 1 in 1970. As with early infectious syphilis, infected homosexual males are

TABLE III *Infections contracted at home and abroad*, 1971

Diagnosis	*Syphilis*		*Gonorrhoea*	
	Number	*Per cent.*	*Number*	*Per cent.*
Contracted in United Kingdom	867	76·6	52,137	93·3
Contracted abroad	201	17·8	2,001	3·6
Unknown	64	5·6	1,752	3·1

TABLE IV *Syphilis tests in pregnancy*, 1971

Centre	*No. of ante-natal patients*			*Positive syphilis tests*					
	Primiparae	*Multiparae*	*Parity not known*	*Primiparae*		*Multiparae*		*Parity not known*	
				No.	*Per cent.*	*No.*	*Per cent.*	*No.*	*Per cent.*
Cambridge	11,454	14,719	553	3	0·03	15	0·10	0	0
Leeds	11,328	6,703	1,868	25	0·22	14	0·21	0	0
Liverpool	22,560	25,107	—	3	0·01	2	0·01	—	—
Oxford	4,535	7,376	966	5	0·11	10	0·14	0	0
Sheffield	23,120	12,227	—	8	0·03	2	0·02	—	—

included. This year the BCCG study has indicated that, if infections acquired homosexually are omitted, the male : female ratio in 1971 is 1·9 : 1.

Information obtained from the clinics on the age breakdown in cases of gonorrhoea per 100,000 population (Table I) showed an incidence of 527·46 in the 20 to 24-age group, 541·06 in the 18 and 19-year age group, 252·47 in the 16 and 17-year age group, and 4·53 under 16 years, as compared with 94·30 in the over 25 years age group; the respective figures for 1970 were 488·53, 505·95, 228·13, 4·11, and 91·91.

Infections under 16 years occurred in 129 boys and 400 girls in 1971 compared with 80 boys and 395 girls in 1970. The incidence of new cases per 100,000 population was only 2·15 in boys as compared with 7·03 in girls in this age group (Table I). The number of cases in boys aged 16 to 19 was 4,393 as compared with 4,106 in 1970, and the number in girls 5,588 as compared with 5,104 in 1970. The incidence of new cases per 100,000 population (Table I) for boys was 161·37 for the 16 and 17-year age group and 523·91 for the 18 and 19-year age group, and for girls was 348·62 in the 16 and 17-year age group and 558·80 in the 18 and 19-year age group. The increasing incidence of gonorrhoea in young people remains the greatest cause for concern. It is sometimes suggested that increasing use of the contraceptive pill is a factor, but it is well known that many girls take the risk of pregnancy, and indeed the incidence of births and legal termination of pregnancy at these ages has risen. The relatively small numbers of patients below the age of 16 years present a difficult problem, particularly if the child is unwilling to inform the parents of the situation. It is of interest that an increasing number of States in the USA have introduced legislation to give the doctor in the clinic legal sanction to examine these children without either parent's knowledge, if this proves necessary.

During 1970 it was possible to take contact action regarding the contacts of 32,565 cases of gonorrhoea, 24,933 in men and 7,632 in women. As a result 19,855 contacts attended a clinic, 5,893 men and 13,962 women. On examination 12,321 of these were found to have gonorrhoea, 3,050 men and 9,271 women. This work has therefore been appreciably more effective than in the past. It should be noted that in a minority of clinics epidemiological treatment is given to all women contacts in whom the diagnosis of gonorrhoea has not been established on the initial examination (BCCG study, 1971) and to this extent a number of cases of gonorrhoea which might well have been diagnosed in further examinations are not recorded.

The main control measure of contact action continues to gain favour with an ever increasing number of physicians in charge of clinics; some requests for the appointment of welfare officers by local health authorities have resulted. The presence of a welfare officer during clinic hours ensures the interview of the patients with gonorrhoea at the first attendance. The short incubation period of the disease makes it more likely than in syphilis that an accurate description of the source contact will be obtained. Welfare officers are now becoming very skilled in this type of interview technique and even when a name and address are not available, a rapid and successful search often results. Valuable time is saved in visiting by the inter-clinic exchange of information and co-operation by welfare officers, and by the co-operation of medical officers of health and the health visitor staff in all parts of the country. Once contacts attend the clinic a rapid diagnosis is usually possible by means of the newer diagnostic techniques mentioned in last year's report. New blood tests for the identification of gonococcal antibodies are under trial in both this country and the United States. These blood tests are not at present suitable for general screening of the population, but may aid diagnosis in known gonorrhoea contacts. In recent years reports of a type of metastatic gonorrhoea with skin manifestations suggest that this condition is becoming more common. Barr and Danielsson (1971), reporting from Sweden, found an incidence of this in 0·4 per cent. of men and 2·3 per cent. of women. A type of gonorrhoea (Iqbal, 1971) caused by changing sex habits has been reported as a result of oro-genital contact leading to gonococcal pharyngitis. These conditions are likely to be occurring in England and will present difficult diagnostic problems to physicians in specialist as well as in general practice.

The total of 55,988 cases included 45 of vulvovaginitis as compared with 33 in 1970 and 53 cases of gonococcal ophthalmia as compared with 59 in 1970. All cases of ophthalmia might have been prevented if ante-natal genital tests for gonorrhoea had been done on women at high risk of infection (Schofield, 1969).

Chancroid

This disease remains a minor problem in England. There were 55 new cases reported in 1971, compared with fifty in 1970. This gives an incidence of 0·12 per 100,000 population as compared with 0·10 in 1970 (Table I).

Other sexually transmitted diseases

Lymphogranuloma venereum and granuloma inguinale

These diseases continue to be rare in England. In 1971 there were 46 cases of lymphogranuloma venereum as compared with 41 in 1970. The incidence per 100,000 population was 0·10. There were five new cases of granuloma inguinale compared with nine in 1970. The incidence was 0·01 per 100,000 population (Table II).

Non-specific genital infection

Research on the causative agent or agents in this group continues to be supported by the DHSS and MRC. It is encouraging that at least four centres are now investigating the role of *Chlamydia* group A organisms in this condition. However, it is still reasonable to suspect that other infective agents are implicated and the possibility that there may be pathogenic strains of mycoplasma cannot be discarded; their isolation in the upper genital tract in women with pelvic complications has been reported from Sweden (Mårdh and Weström, 1970). Some type of allergic reaction in male patients with recurrent urethral infections cannot be excluded. The diagnosis of infection in female sex contacts remains a difficult problem, but their diagnosis and treatment seems indicated when there is evidence of inflammatory changes in the genito-urinary tract. This year these cases have been reported under a separate heading. Thus there was a total of 72,420 cases, 59,023 in men and 13,397 in women. The incidence was 157·13 per 100,000 population, 263·55 in men and 56·54 in women (Table II). The figure in men is not exactly comparable with previous years as it now includes non-specific proctitis to bring it in line with post-pubertal gonorrhoea in the male. There were 420 cases of non-specific urethritis with arthritis in males and thirty cases in females in 1971, compared with 373 cases in males in 1970. The incidence in males was 1·88 per 100,000 in 1971 (Table II).

Trichomoniasis

There were 1,300 male cases and 17,407 female cases reported from the clinics in 1971, as compared with 1,290 male cases and 14,491 female cases in 1970. When patients with this conditon, which is commonly sexually transmitted, present in other out-patient clinics or in general practice, doctors who do not refer cases to special clinics should at least make certain that their patients have not got a venereal disease or any other sexually transmitted condition. In spite of the difficulty in isolating *T. vaginalis* from the male genito-urinary tract, the method of handing the infected female a supply of tablets for her sex partner (who is not investigated) is to be discouraged.

Candidiasis

Separate figures reported for the first time in 1971 gave a total of 24,420 cases, 2,881 in males and 21,539 in females. *Candida*, which may occur in the genital tract as a saprophyte, can become a pathogen in pregnant women or in either sex as a result of glycosuria. More recently it has been realized that factors such as the administration of a tetracycline drug or the oral contraceptive pill can produce a similar reaction. As a result this organism is often sexually transmitted, and can only be eliminated when both sex partners receive treatment.

Scabies and pediculosis pubis (pubic lice)

Although both these infestations spread chiefly among families or others in crowded conditions with poor standards of hygiene in developing countries, in developed countries they are usually spread in adults by close bodily contact of a sexual nature and this may be associated with venereal and other sexually transmitted diseases (Fisher and Morton, 1970). In 1971 there were 3,262 cases of scabies reported from the clinics, 2,528 in men and 734 in women; in the same year there were 4,054 cases of pediculosis pubis, 3,070 in men and 984 in women. The incidence of pediculosis pubis was 8·80 per 100,000 population, 13·71 in men and 4·15 in women (Table II).

Genital herpes, genital warts (condylomata acuminata), and genital molluscum

The virus of herpes simplex causing genital infection (HSV II) can now be easily isolated by virologists and thus the venereologist can make a definitive diagnosis. The possible relationship of HSV II to carcinoma of the cervix (*Lancet*, 1970) has greatly increased the importance of exact diagnosis and of the recording of the incidence of this infection which appears to be commonly sexually transmitted. There were 3,671 cases recorded at the clinics in 1971, 2,736 in men and 935 in women.

Recent research by Oriel (1971) has also shown that genital warts are normally sexually transmitted and differ in certain respects from common warts on the skin; they can have a long incubation period. In 1971 13,730 cases were reported in the clinics, 8,916 in men and 4,814 in women. The incidence was 29·79 per 100,000 population, 39·81 in men and 20·32 in women (Table II).

The virus of molluscum contagiosum when it occurs in the genital region is usually sexually transmitted (Cobbold and Macdonald, 1970) and a definitive diagnosis can be made. There were 514 cases of genital molluscum seen at the clinics in 1971, 371 in males and 143 in females. All these viral conditions should be considered by doctors seeing cases in hospital or in general practice as potentially sexually transmitted, and venereal diseases and other sexually transmitted conditions should be excluded by them or else the patient should be referred to a special clinic.

Other conditions

The total in 1971 of other conditions requiring treatment was 29,478, consisting of 20,926 cases in men and 8,552 cases in women. The incidence was 63·96 per 100,000 population, 93·44 in men and 36·09 in women (Table II). These figures are not comparable to those of previous years. Most of these cases are of minor non-sexually transmitted conditions requiring simple local treatment.

Patients with no genital disease supply the majority of those included under the heading 'conditions requiring no treatment in the clinic' but there are a few with serious disease needing transfer to other hospital departments, such as genital carcinoma, or cases of disease of other systems of the body diagnosed by general physical examination of the patient, as a result of the basic training in general medicine which is essential to the physician specializing in venereology. There was a total of 69,260 cases in this category, 44,714 males and 24,546 females.

The present position

In the 1970 report the increased strain on clinic resources was noted; a paper by Catterall and Morton (1970) presented a more detailed analysis of the situation. During 1971, however, although the number of new cases rose again, various measures taken to strengthen the service had begun to take effect. In recent years there has been little or no increase in the number of consultants in venereology, nor are there many suitable candidates available for promotion as the recruitment at senior registrar level has been very poor, especially in the provinces. This year appointments have been made in new senior registrar posts as well as in existing vacancies. In addition a number of new training posts at registrar grade have been created in some cases shared with general medicine. These new appointments should help the present situation and will also make possible an increase in consultant establishment in a few years' time. Increases in staff, however, will not be feasible without improvements in clinic facilities. A survey by the Department of the 179 clinics in England showed that the premises situation was considered satisfactory in 109; in the remaining seventy, considered inadequate, a new clinic or upgraded clinic was planned in 35 by 1975 and in addition nineteen after 1975; in only sixteen were no alternatives proposed, but plans for eventual upgrading have been initiated in several of these since the survey.

Research projects on various aspects of the sexually transmitted diseases continue to be supported at major centres by the MRC and by the DHSS. Work on a new serological test for gonorrhoea and further research on the role of *Chlamydia* in the aetiology of non-specific urethritis are two of a number of those research projects which may make a contribution to the diagnosis and control of disease in this field. Work in the USA and Poland continues on problems of immunization against syphilis in various types of animal experiments, but little progress has been made towards successful human protection. In the United States work is also being carried out on various types of local genital prophylaxis, by pessary, application, and spray, but it seems unlikely that diseases which need systemic treatment for cure can be controlled in this way.

Control by epidemiological treatment and the 'cluster' method of treatment is also popular as a disease control technique in the United States where only 15 per cent. of venereal disease cases present to the clinics controlled by the Public Health Service. These clinics are not staffed by clinicians trained in venereology. This leads to a policy of treating known sex contacts of early infectious syphilis and gonorrhoea before diagnosis. Such a line of action is only indicated in the United Kingdom on rare occasions when dealing with individuals who are unreliable or in transit and who may default after a single clinic attendance. All other contacts can be diagnosed rapidly if modern techniques are employed, and treated if the disease is confirmed.

Developments in the field of health education continue to be promoted by the Health Education Council. The trouble with campaigns launched *via* the mass media in order to reach the vast mass of the adult population is that the majority of those who then attend the clinics are anxiety-prone members of the public with no organic disease. They take up valuable clinic time and make it more difficult to cope with those who need treatment. The problem is to know the best way to reach those individuals considered to be most at risk. In a recent campaign in a London Borough, a 20-minute recording of

pop music with a playlet on venereal disease sandwiched in between was presented. It can be played as a cassette or as a tape in a recorder, and it was felt it might help to reach the younger generation. Another method used in some areas is recorded information service, by which members of the public can dial an advertised telephone number and hear a recorded message on sexually transmitted diseases together with the address of the local clinic.

Rapid and successful contact tracing of patients with early infectious syphilis and gonorrhoea has first priority in the control of venereal diseases. Contact tracing in all the other sexually transmitted diseases is also, of course, of prime importance in disease control. During 1971 a conference on contact action, at the DHSS, was attended by physicians in charge of clinics and medical officers of health of Greater London Boroughs, SAMOs, Chairmen of LMCs, and a number of welfare officers experienced in venereal disease contact tracing work. It was agreed that there was a need to improve contact tracing, particularly for gonorrhoea, and that a start should be made in the GLC area, as nearly 50 per cent. of infections in the whole of England occurred in this area. It was recommended that every clinic should have a welfare officer on duty during clinic hours to interview patients and that medical officers of health should designate health visitors in their boroughs to help the clinic welfare officers in the search for contacts in their area. Lists of welfare officers and designated health visitors with telphone numbers were to be circulated. Welfare officers were employed by the borough and seconded for duty in the clinic: at least two welfare officers were needed in the major clinics. The possibility of a central office for correlating contact information was discussed: further consideration of this had been deferred until a feasibility study can be made. The role of GPs in the control of venereal disease was also discussed, and it was suggested that a futher pilot study was needed to estimate the number of cases treated by them rather than referred to their local special clinic. Facilities for diagnosis and contact tracing would need to be provided in these cases.

There is also a need for clinics to be fully staffed with both male and female nurses. The Board of Clinical Nursing Studies was set up to consider post-basic nursing training and one of the subjects under consideration is a course in sexually transmitted diseases. It is hoped that this may result in the formation of a number of training centres to help recruitment in this particular post-basic subject. Clinics, however modern and adequately staffed with doctors and nurses, will not function efficiently without ancillary staff, such as medical social workers, welfare officers, receptionists, and secretaries. Local hospital authorities need to support physicians in charge with this essential additional staff if their clinics are to function at the top level of efficiency. This year the statistical returns for the clinics have been reorganized on a quarterly basis without a separate annual return, in a number of larger clinics use has been made of the hospital computer services, working on a case code sheet system.

A Franco-Swedish study promoted by WHO should indicate that unless valid statistical returns of case diagnoses are made, no country can assess its problem in this field. The WHO meeting in Copenhagen on the international aspects of contact tracing in Europe shows the importance of the greatly increased population mobility of this decade. It was appreciated that no country could play its full part in venereal disease control internationally unless it first had a fully organized national service. These developments should encourage venereologists in this country to make a particular effort in 1972 to increase the standards of efficiency of their clinics to the benefit of the Service as a whole.

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